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News, tips, info, details, and ideas brought to you by the Clinical Center JCAHO Work Group

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Medical Records ----History and Physical Exams: All H&P's must be performed and documented (*including date and time*) within 24 hours of an inpatient admission.

Release of Medical Information

- Requests for release of medical information, authorized by the patient, should be forwarded promptly to the MRD's Medicolegal Section (10/1N216) for processing. Such authorizations should be complete, with patient signature and the address of the requested recipient of the records. A complete name and address for the recipient must be noted on the request in order to assure the requested material is routed properly and expeditiously. The addresses present in the medical record may be outdated and cannot be assumed to be accurate for routing of material.
- The MRD forwards copies of dictated inpatient discharge summaries to physicians listed in MIS to receive reports as identified by the patient upon completion.

General Medical Record Documentation Requirements

- All handwritten entries must be written LEGIBLY.
- All entries must be dated and signed.
- Incomplete medical records must be dictated and signed within 30 days of the outpatient visit or inpatient discharge before they become delinquent.
- Patient name and medical record number must be included on all documentation to be filed in the medical record.
- It is not recommended that email be utilized to communicate patient care related information. However, if email must be utilized to communicate critical information to members of a patient's health care team, such information must be sent via SECURE email only. Email documentation should *never* take the place of documenting clinical or diagnostic information in the patient's medical record.
- All forms must be reviewed and approved by the Medical Record Committee (contact the MRD on 496-2292 to obtain further guidance on form development/design).

Medical Record Maintenance

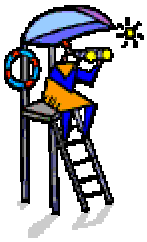
- For *inpatient admissions*, all parts of the medical record must be returned to the Record Management Section (10/1N211) within 48 hours following discharge.

*** Remember to practice locating specific documentation within the medical record/unit chart. The 'Medical Record Cheat Sheet' is a good resource to utilize when practicing. Please contact the Medical Record Department if you would like assistance during your practice sessions or need a copy of the 'Medical Record Cheat Sheet' document.(496-2292)*

- For *outpatient visits*, all parts of the medical record must be returned to the Record Management Section (10/1N211) within 24 hours of the last scheduled appointment.
- ***It is important that records are returned promptly to the MRD so they are available for future patient care encounters.***

- Medical records transported by or with a patient are to be placed in a blue transport bag and secured with a plastic locking device. Transport bags and plastic locks may be obtained from the Medical Record Department (496-2292).

Medication Information



1. One of the National Patient Safety Goals is to improve safety of using high-alert medications. What is a high-alert medication? What precautions has the Clinical Center taken to meet this goal? High-alert drugs are those with potential for serious adverse outcome or a high risk of injury if an error occurs or if misused. They include insulin, hypertonic sodium chloride, controlled substance infusions, concentrated electrolytes, IV anticoagulants, cytotoxic agents, IV vasoactive agents, and neuromuscular blockers Part 1 of this goal is intended to assure safe use of concentrated electrolytes. Specific safety strategies have been already been implemented for:

- ***Potassium chloride***: Undiluted vials of potassium are restricted to pharmacy use only and may not be dispensed to any department or patient care unit. Potassium chloride infusions are provided either as commercially available pre-mixed products or IV admixtures compounded by Pharmacy.
- ***Hypertonic sodium chloride***: 3% NaCl infusions must be obtained from pharmacy. Nurses must verify concentration, infusion rate, and line attachment before initiating an infusion; this warning message appears in all 3% NaCl orders entered in MIS.

Are magnesium and calcium injections also included as high-alert drugs?
Yes; a risk assessment was performed by Pharmacy to evaluate the need for additional safety measures with IV calcium and magnesium:

- ***Calcium gluconate and calcium chloride***: Administration of undiluted injection is restricted to urgent situations such as code blue or per protocol treatment of life threatening hypocalcemia. Routine electrolyte replacement solutions are prepared in pharmacy. Several units have voluntarily deleted calcium gluconate from floor stock.
- ***Magnesium sulfate***: The pharmacy department has initiated a transition to pre-mixed magnesium sulfate infusions for urgent magnesium replacement. Concentrated magnesium sulfate will be removed from patient care units as the transition takes place.

What about Part 2 of the high-alert goal: standardizing and limiting the number of concentrations of high alert drug infusions? IV opiates, insulin, and heparin infusion concentrations have been standardized. With implementation of the Alaris Guardrails System™, libraries of standardized concentrations are being established for many more IV medications.

3. What abbreviations/denotations are prohibited in medical order writing?
They are "***MSO4, u, qhs, qod, µg,*** and ***cc***." The use of a trailing zero, e.g. Coumadin ***2.0 mg***; and absent leading zero, e.g. clonidine ***.1 mg***, is also prohibited. If an abbreviation on the list is used in a written order, it must be clarified in writing before the order can be acted upon. A

list of unacceptable abbreviations is posted on computer terminals, in the front of patient charts, and at: http://www.cc.nih.gov/medbrd/abbreviations/unacceptable_abbreviations.html

4. What has implementation of the National Patient Safety Goals changed about verbal orders for medications? Verbal orders are discouraged except for emergency situations. When a verbal order is necessary, the person taking the order must now write down the order and read it back to the prescriber, *rather than simply repeating it*. To avoid misinterpretation of numbers, "cockpit" language is used. Say "one, six" instead of "sixteen"; "five zero" instead of "fifty." Any verbal orders using unacceptable abbreviations may also be clarified during read-back.